STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY STREET LAKE STATION, IN46405

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R0000	This visit was for the State Licensure Survey. This visit also included the Investigation of Complaint 00085473. Complaint Number 00085473: Substantiated, no deficiencies related to the allegation are cited. Survey Dates: May 9, 10, &11, 2011 Facility Number: 001136 Provider Number: 001136 AIM Number: N/A Survey Team Heather Tuttle, R.N. T.C. Janet Adams, R.N. 5/9 & 5/10/11 Kathleen Vargas, R.N. 5/9 &5/10/11 Census Bed Type: 114 Residential 114 Total Census Payor Type: 114 Other 114 Total Sample: 11 Supplemental Sample: 13	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These State Residential Findings are cited in accordance with 410 IAC 16.2. Quality review completed on May 116, 2011 by Bev Faulkner, RN			
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			
	Based on record review and interviews, the facility failed to ensure the resident's physician was promptly notified of a change in condition related to pain and a new bruise, the repeated refusals of medication, and the availability of an antibiotic from the pharmacy for 3 of 11	R0036	Deficiency #: R036Residents Affected: #2, #4, #51. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #2's physician has been notified of fall incident. Resident #4's physician was notified of non administration of Procrit. Resident #5's physician has been notified of the medicaid required authorization which led to the late delivery of Zithromax.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected by this alleged deficient practice. Residents' medical records will be audited randomly every month to ensure compliance.3. What	06/23/2011

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	residents reviewed for physician notification in the sample of 11. (Residents #2, #4, and #5) Findings include: 1. The record for Resident #2 was reviewed on 5/9/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to, weakness, high blood pressure, anemia and congestive heart failure. Nursing Progress Notes,		measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nurses will be in serviced on notifying physician of any changes in condition, non-availability of medication, administration of medication and resident falls.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Director of Nursing or designee will randomly check ten (10) percent of residents clinical records on a weekly basis and verify notification of physician for all changes in condition, falls, availability of medication and administration of medication. Monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	dated 10/9/10 at 3:30 a.m., indicated the resident had complaints of pain and wanted a pain pill. The resident indicated at that time, that she had rolled out of bed and her left side was hurting her. The resident refused to go to the hospital at that time. Hydrocodone APAP (a pain medication) 7.5/750 milligrams was given to the resident for her pain. The next documented entry in Nurse's Notes was on 10/11/10 (2 days later) at 10:00 p.m., which indicated the			

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	resident had complaints of pain on her lower left side of her back. The resident was examined by the nurse and was found to have a bruise on her left back. There was no documentation the resident's physician was notified at that time. The next documented entry in Nurse's Notes was on 10/13/11 (2 days later) which indicated the resident returned from the Physician's office with new orders for a hospital bed. Review of Physician			

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	Progress Notes, dated 10/13/11, indicated "Contusion left chest, hematoma left chest area, possible rib contusion. Will ask for a rail for the bed. Review of the Incident Report Statement, dated 10/9/11, indicated the resident's physician was not notified of the fall out bed. Interview with Administrator on 5/10/11 at 2:45 p.m., indicated the resident's physician had not been notified of			

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	the fall or the bruised area until the resident went to the physician's office four days later. 2. The record for Resident #4 was reviewed on 5/9/11 at 12:10 p.m. The resident's diagnoses included, but were not limited to, lymphoma, iron deficiency, and anemia. Review of the 5/11 Physician Order Statement indicated there was an order for the resident to receive Procrit (a medication to treat low blood counts) 10,000 units injection weekly on Fridays. The Physician Order Statement indicated the medication was originally ordered on 11/26/10. The 1/11, 2/11, 3/11, and 4/11 Medication Administration Records were reviewed. On the 1/11 Medication Administration record the Procrit injection was circled as not given on 1/7/11 and 1/28/11. The 1/14/11 and 1/21/11 entries were blank. There was no documentation on the back of the 1/11 Medication Administration Record indicating the reason the medication was not given or not signed out as given.			

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	The 2/11 Medication Administration Record indicated the Procrit injection was not signed out as given on any days throughout the entire month. There was no documentation on the back of the 2/11 Medication Administration Record indicating the reason the medication was not signed out as given. The 3/11 Medication Administration Record indicated the Procrit injection was circled as not given on 3/11/11, 3/18/11, and 3/25/11. There was no documentation on the back of the 3/11 Medication Administration Record indicating the reason the medication was not given. The 4/11 Medication Administration Record indicated the Procrit injection was circled as not given on 4/1/11 and 4/15/11. The 4/8/11, 4/22/11, and 4/29/11 doses were blank. There was no documentation on the back of the 4/11 Medication Administration Record indicating the reason the medication was not given or not signed out as given. Nurses' Notes for the months of 1/11 through 4/11 were reviewed. There was no documentation of the Physician being notified of the Procrit injections not being given on the above dates as ordered.			

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	When interviewed on 5/10/11 at 1:45 p.m., the facility Administrator indicated the physician should have been notified of the medication not being given as ordered. 3. The record for Resident #5 was reviewed on 5/9/11 at 12:30 p.m. The resident had diagnoses that included, but were not limited to, congestive heart failure and diabetes. There was as entry in the Nurse's Notes, dated 10/22/10 at 1:45 p.m., that indicated, "To Dr. (doctor's name) office via in-house transport. C/O (complains) of cold symptoms." There was a physician's order, dated 10/22/10, that indicated, "Zithromax (an antibiotic) 250 mg (milligrams), 2 pills x 1 day and 1 pill x 4 days for sinus infection." The entry in the Nurse's Notes dated, 10/23/10 at 9:30 a.m., indicated "Resident down to nursing for meds. New order for Zithromax not here, paper faxed over to pharmacy, Medicaid denied claim because plan limits were exceeded." An entry in the Nurse's Notes, dated 10/23/10 at 10:00 a.m., indicated, "Pharmacy called back and stated that Zithromax would not be covered and they would not be able to call			

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	Medicaid about it until Monday." The entry in the Nurse's Notes, dated 10/23/10 at 8:15 p.m., indicated, "Resident at nurse's station. Requests antibiotic. Antibiotic unavailable at this time. Resident became upset. Became agitated attempted to redirect." Continued review of the Nurse's Notes indicated the physician was not notified that the antibiotic Zithromax that was ordered for the resident, was not available and could not be administered. Interview with the Business Office Manager 5/10/11 at 2:30 p.m., indicated the pharmacy sent the Zithromax to the facility on 10/26/10. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated the physician should have been notified that the antibiotic was not available.			

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R0050	(t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s			

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	legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate. Based on record review and interviews, the facility failed to ensure every resident received interest on their money for funds greater than 100.00 dollars for 5 of 5 residents reviewed for funds in supplemental	R0050	Deficiency: R050Residents affected: Residents# 18, #19, #20, #21, #221. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?Residents #18, #19, #20, #21, and #22's personal funds accounts have the interest credited to their accounts and are in the process of being notified of the interest that has been credited.The bank has been contacted and the account has been changed to an interest bearing account.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will	06/23/2011

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	sample of 13. (Residents #18, #19, #20, #21, and #22) Findings include: Review of the Resident Funds account on 5/10/11 at 1:15 p.m., indicated the following: Resident #18 had $1803.27 in the account. Resident #19 had $625.00 in the account. Resident #20 had $873.47 in the account. Resident #21 had $1121.23 in the account. Resident #22 had		be taken?All residents with personal fund accounts in the excess of one hundred ($100) dollars have the potential to be affected by this alleged deficient practice. The Business Office Manager will audit all resident personal funds accounts and will credit the interest to all accounts in excess of one hundred ($100) dollars. The residents will be notified of the interest credited.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?The Corporate office that is handling the interest to be credited will be in serviced on the regulations regarding personal fund accounts. The Business Office Manager that handles the resident personal fund accounts in the facility will be in serviced on the regulation. The Business Office Manager will ensure the interest has been credited to resident person fund accounts in excess of one hundred ($100) dollars on a quarterly basis. Business Office Manager and Corporate office staff will review each residents personal fund statement to ensure interest has been added.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Business Office Manager or designee will monitor the resident personal funds accounts on a quarterly basis and	

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	$962.57 in the account. Review of the 2009 and 2010 bank statements for each of the listed residents indicated no interest had been credited to their accounts. Interview with the Business Office Manager on 5/10/11 at 1:30 p.m., indicated she was able to access their account information online; however, the corporate office kept track of the amount of credits, debits, and interest for each of		will provide the information to the resident on a quarterly basis and or upon request. The Administrator will monitor ongoing for compliance.5. By what date the systemic changes will be completed? June 23, 2011	

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	the accounts.			
R0120	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			

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	Based on record review and interviews, the facility failed to ensure new employees received six hours of dementia training within the first six months of employment for 2 of 5 employees whose were files reviewed. (RN #1 and Housekeeper #1) Findings include: Review of the employee files on 5/10/11 at 9:30 a.m., indicated RN #1 was hired on 6/14/10 and Housekeeper #1 was hired on 8/23/10.	R0120	Deficiency: R120Residents Affected: RN#1 and Housekeeper#11. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?Housekeeper #1 has completed the balance hours of the required Dementia training hours.RN#1 will complete the balance of hours needed for completion upon return from Medical leave.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?All hired employees within the last six months have the potential to be affected by this alleged deficient practice. All employee files are being audited to ensure the six hours of dementia training requirement is met.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?All administrative Staff will be in serviced on the Dementia Training Requirement for all newly hired employees. New employees will be required to complete Dementia Training one (1) hour per month for the first six months of employment. If an employee does not complete the training for that month, they will be suspended and subject to termination. A new form will be iinstituted to track each	06/23/2011

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	Review of the dementia training inservices from 6/10 until 4/11 indicated the RN or the Housekeeper had not completed the required six hours of dementia training within the first six months of employment. Interview with the Assistant Administrator on 5/10/11 at 10:45 a.m., indicated both of those employees had not completed the required six hour of dementia training within the first six months of		employee's dementia training compliance.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?Business Office Manager will audit the newly hired employee files monthly for Dementia Training and will review tracking form to ensure compliance and will report findings to Administrator. This monitoring will be ongoing by Administrator or designee.5. By what date the systemic changes will be completed? June 23, 2011	

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	employment.			

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R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review	R0121	Deficiency: R121Residents affected: RN#1, CNA#1, and CNA#21. What corrective action	06/23/2011

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	and interview, the facility failed to employ the second step Mantoux method after the administration of the first step Mantoux test for 3 of 5 employee records reviewed. (RN#1, CNA #1, and CNA#2) Findings include: Review of the employee files on 5/10/11 at 9:30 a.m., indicated the following: RN #1 was hired on 6/14/10 and received a first step Mantoux test		(s) will be accomplished for those residents found to have been affected by the deficient practice?RN#1 will complete Mantoux Test Procedure upon return from Medical Leave. CNA#1 and CNA#2 have completed the 2 Step Mantoux Process and are in compliance.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?Newly hired employees have the potential to be affected by this alleged deficient practice. All newly hired employee files within last six months will be audited.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?The polices have been reviewed with Administrative Assistant, Nursing Staff, and Management Staff and they are being inserviced on Mantoux Method and the time restraints of which steps must be completed when an applicant is hired by the facility. The new applicant will be given a return date to complete the second step and if the applicant does not return on the date given, the employee will be terminated. Facility staff not adhering to policy regarding Mantoux Method will be disciplined.4. How the corrective actions will be monitored to ensure the deficient practice will	

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	on 6/2/10. CNA #1 was hired on 9/13/10 and received a first step Mantoux test on 9/11/10. CNA#2 was hired on 12/10 and received a first stet Mantoux test on 12/4/10. There was no second step Mantoux test completed for any of the above employees within 2 to 4 weeks after receiving the first step. There was no documentation from the previous 12 months that they had received a		not recur?Business Office Manager or designee will review all paperwork for new hires and will keep track of return dates for newly hired employees needing the Second Step of Mantoux to ensure compliance ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	tuberculin skin test. Interview with the Assistant Administrator on 5/10/11 at 10:45 a.m., indicated the mentioned employees did not receive a second step Mantoux within 2 to 4 weeks after the first step.			
R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the environment was clean and in a state of good repair related to torn wallpaper, chipped	R0144	Deficiency #144Residents affected: All 114 Residents1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?Room 205- Curtain was laundered and spare curtains will be ordered. Room 215 Door will be sanded and painted; Scuffed marks removed; Bathroom walls cleaned; Caulking redone on bathtub. Room 220 Curtain laundered. Room 124- Exhaust	06/23/2011

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	paint on door frames, cracked and discolored caulking, stained window curtains, splintered door, dusty ceiling exhaust vents, paint chipped on walls, marred and rusty floors, and sink faucet missing a handle in 5 resident rooms on the first floor, 3 resident rooms on the second floor, 2 of 2 dining rooms, and 1 of 1 activity area. This deficient practice had the potential to affect the 114 residents residing in the facility. (The first and second		fan vent cleaned; Bottom of door cleaned. Room 130 Wall paper secured to wall.; Bottom of bathroom door repainted. Room 156 wall paper secured. Faucet handle replaced. Room 171 Shower bar replaced. Brick wall repainted. Ceiling tiles above vending machines cleaned. Door frames between small and large dining room repainted.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?All residents have the potential to be affected by this alleged deficient practice. All resident rooms are being checked for cleaning and repair issues by Environmental Service Director or designee.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?All housekeeping and Maintenance staff will review policies and procedures on cleaning and repairs.All Housekeeping and Maintenance staff will be in serviced on Housekeeping concerns and Maintenance issues and that these concerns should be cleaned or repaired immediately and reported to the Environmental Services Director as needed.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Environmental	

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	resident floors, the small and large Dining room, and the Activity room area.) Findings include: 1. During the Environmental tour on 5/10/11 at 9:40 a.m., the following was observed on the second floor: a. There were gray stains on the window curtain in Room 205. Two residents resided in this room b. The wood was		Services Director will monitor cleaning and repair concerns on a weekly basis by making rounds daily and checking 5 rooms per week to ensure that resident rooms and common areas are being cleaned and that repairs have been completed in a timely manner to ensure compliance. Monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	splintered on the bottom of the bathroom door in Room 215. There were gray and black scuffed marred areas on the bathroom floor. The bathroom walls were dirty. There were pieces of caulking broken off in the bathtub. Two residents resided in this room. c. There were brown stains on the window curtain in Room 220. One resident resided in this room. When interviewed at this			

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	time, the Maintenance Director indicated the above areas were in need of cleaning or repair. 2. During the Environmental tour on 5/10/11 at 9:55 a.m., the following was observed on the second floor: a. The was an accumulation of dust on the ceiling exhaust fan vent in Room 124. The bottom of the bathroom door was rusty. Two residents resided in this room.			

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	b. There was an accumulation of dust on the ceiling exhaust fan vent in Room 120. Two residents resided in this room. c. The wall paper was peeling on the wall corners next to bathroom exit area in Room 130. The paint on the bathroom door frame was chipped. The bottom of the bathroom door was marred. One resident resided in this room. d. The wall paper in the			

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	bathroom in Room 156 was torn. A piece of the faucet handle was missing on the sink. Two residents resided in this room. e. The caulking along the inside of the bathtub was black and discolored in Room 171. The bar for the shower curtain was rusty. The paint was chipped on the brick wall between the window and the window register vent. Two residents resided in this room.			

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	When interviewed at this time, the Maintenance Director indicated the above areas were in need of cleaning or repair. 3. During the Environmental tour on 5/10/11 at 10:30 a.m., the following was observed in the Dining rooms and the Activity room areas: a. There were three stained ceiling tiles above the vending machines at the entrance to the Activity room.			

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	b. The paint on the door frames of the two door between the small and large dining rooms was chipped. When interviewed at this time, the Maintenance Director indicated the above areas were in need of cleaning or repair.			
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interviews, the	R0154	Deficiency 154Residents Affected: All 114 Residents1. What Corrective action (s) will be accomplished for those residents found to have been affected by	06/23/2011

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	facility failed to ensure food was prepared and served under sanitary conditions related to dusty and dirty ceiling, dirty and greasy transportation carts, dirty floors, dirty PVC pipes, greasy equipment and dirty ovens, for 1 of 1 kitchen areas. This had the potential to affect 114 residents who resided in the facility. (The Main Kitchen) Findings include: 1. During the full Kitchen Sanitation Tour		the deficient practice?Dish machine and ceiling of dish room were cleaned during survey. Four transportation carts were cleaned including wheels. PVC pipes and white wall under the three compartment sink cleaned. Baseboard under the three compartment sink cleaned. Both trash barrels cleaned. Food prep table cleaned. The area under the wire racks were cleaned of burned food. Top and bottom of convection ovens cleaned. Wall by convection oven cleaned. Dust and grease on side and behind stove cleaned. The griddle was cleaned immediately during survey.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents in the facility have the potential to be affected by this deficient practice. Dietary Staff were informed that kitchen needs to be kept clean.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All Dietary staff will review policies and procedures on cleaning kitchen equipment and environment .Dietary Staff will be in serviced by Dietary Supervisors on cleaning schedule of kitchen and equipment. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? The	

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	on 5/9/11 at 9:20 a.m., the following was observed: A. There was a large amount of dirt and food particles on top of the dish machine. B. There was adhered dust noted on the ceiling in the dish room. C. Four transportation carts that hauled coffee and water and other food were stained and dirty. The wheels were greasy and dirty.		Dietary Supervisor and Assistant Dietary Supervisor will monitor the cleaning of the kitchen and equipment and will ensure the staff is adhering to schedule by doing daily and weekly checks. Staff not adhering to the cleaning schedules will be subject to disciplinary actions. Daily and weekly monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	D. The white PVC pipes under the three compartment sink were dirty with dried food noted on them. The white wall underneath the three compartment sink was food stained. E. There was adhered dirt and dust noted against the baseboard under the three compartment and food prep sinks. F. The two trash barrels were dirty. G. The sides of the food			

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	prep counter and on the back side of the equipment were dirty with a heavy accumulation of grease, dust and dirt. The silver coils were also dusty and greasy. H. There was a large amount of food crumbs and dirt under the food prep table. I. The top and bottom of the convection ovens were dirty and greasy. There was burned food noted under the wire racks inside the ovens.			

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	J. The wall by the convection oven was dirty with food spillage noted. K. There was dust and grease noted on the sides of the stove and behind the stove. L. The griddle was greasy and dirty on the sides and on the back side. Interview with the Dietary Food Manager at that time, indicated all of the above was in need of			

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	cleaning.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure an evaluation of the resident's needs was updated at least semiannually for 1 of 11 residents in the sample of 11 who were reviewed for semi-annual assessments. (Resident #4) Findings include:	R0214	Deficiency #: R214Residents Affected: #11. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 has been evaluated and a semi annual assessment was completed during survey.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected by this alleged deficient practice. All residents are being evaluated and due assessments will be completed.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nurses will be re in-serviced on completing all semi annual assessments when due. A new policy will be insituted on completion of semi annual assessments and nursing staff will review.4. How the corrective actions will be monitored to	06/23/2011

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	The record for Resident #4 was reviewed on 5/9/11 at 12:10 p.m. The resident was admitted to the facility on 7/11/08. The resident's diagnoses included, but were not limited to, diabetes mellitus, glaucoma, depressive disorder, lymphoma, high blood pressure, and neuropathy. The resident's semi annual evaluations were reviewed. The most recent semi annual evaluation was completed on 10/19/10.		ensure the deficient practice will not recur?The Director of Nursing or designee will provide a schedule of due assessments and will check off completed assessments on a monthly basis.5. By what date the systemic changes will be completed? June 23, 2011	

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	There were no semi annual evaluations available after 10/19/10. When interviewed on 5/10/11 at 1:45 p.m., the facility Administrator indicated the semi annual evaluations should have been done every six months.			
R0215	(b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on record review and interview, the facility failed to ensure a	R0215	Deficiency #: R215Residents Affected: #61. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Pre-admission	06/23/2011

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	preadmission evaluation was completed for 1 resident in the sample of 11. (Resident #6) Finding includes: The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, diabetes, mental retardation and schizophrenia with auditory hallucinations.		evaluation has been completed for Resident # 62. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected by this alleged deficient practice. Pre admissions evaluations have been completed for all residents in the facility.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nursing and Administrative Assistant will review new form instituted for pre admission screening.Pre admission Nurse designee and Administrative Assistant will be in-serviced on completing all preadmission evaluation prior to resident admission.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Director of Nursing or designee will maintain a check list record of all admissions to the facility ensuring that the preadmission evaluation requirement is met prior to all admissions. Monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	There was no preadmission evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no preadmission evaluation completed for the resident.			
R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			

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	Based on record review and interview, the facility failed to ensure an evaluation to self-administer medications was completed for 1 of 2 residents who self-administered medications in the sample of 11 (Resident #16) and 1 of 13 residents in the supplemental sample of 13 (Resident #14). Findings include: 1. The closed record for Resident #16 was	R0216	Deficiency #: R216Residents Affected: # 16, #141. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 16 no longer resides in the facility.Resident # 14 has been re-assessed for self medication administration2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents in the facility have a potential to be affected. All residents in the facility meeting self administration of medication criteria will be assessed.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?Nurses are being in -serviced on assessing residents for self administration of medications. Nursing staff will then complete self administration form and place on clinical record. The self administration policy will be reviewed by nursing staff.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Director of Nursing or designee will maintain a check list record of all residents deemed capable of self administration of meds and will monitor ongoing.5. By what date the systemic changes will be	06/23/2011

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	reviewed on 5/9/11 at 2:00 p.m. The resident had diagnoses that included, but were not limited to, insulin dependent diabetes and hypertension. The January 2011 Physician Order Sheet indicated the resident was to receive 70 units of Lantus insulin twice daily. Review of the forms titled "Glucometer and Insulin Reading Form" indicated the resident self administered his		completed? June 23, 2011	

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	insulin from 10/17/10 through 1/10/11. The policy titled "Preparation for Medication Administration" was provided by the Administrator on 5/10/11 at 12:00 p.m. She indicated the policy was current. The policy indicated: "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and			

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	visual ability to carry out this responsibility, during the care planning process." Review of the resident's record indicated there was no assessment completed of the resident's ability to self-administer insulin. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had not been an assessment of the resident's ability to self-administer insulin.			

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	2. On 5/9/11 at 1:15 p.m., Resident #14 was observed receiving her medications at the nurse's station. LPN #1 asked the resident if she had completed her nebulizer treatment. The resident indicated she had completed the nebulizer treatment. Review of the May 2011 Medication Administration Record for Resident #14 on 5/9/11 at 1:30 p.m., indicated a physician's			

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	order for Ipratropium/Albuterol inhalation solution, use 1 vial per nebulizer four times daily. The medication administration record had an "S" documented four times per day, May 1 through May 9, 2011. Review of the Resident #14's record on 5/9/11 at 2:00 p.m. indicated the resident had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease.			

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	Review of the 2011 April Medication Administration Record indicated a "S" was documented four times per day for the nebulizer treatment from April 1 through April 30. Interview with RN #1 on 5/10/11 at 11:15 a.m., indicated the "S" means that the resident self administers the medication. A form titled, "Medication Self Administration Assessment" that was			

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	dated 11/12/07 was in the resident's record. It indicated the resident is "forgetful-confusion at times noted." There was no current assessment of the resident's ability to self administer medications. The resident's Service Plan, dated 5/5/11, indicated, "Staff to administer medications to resident." Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there was no current			

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	assessment of the resident's ability to self-administer medication.			
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and inttierview,ttihe facilittiy failed ttio ensure a licensed nurse was monittioring and supervising ttihe administtirattion of medicattions and residenttial nursing care as ordered by ttihe physician relattied ttio insulin administtirattion and glucose ttiesttings,administtirattion of Procrittin,ttiaining ordered lab specimens and monittioring blood pressure for 6 of 11 sampled residenttis reviewed for following physician orders. (Residents #2, #3, #4, #5, #6, & #17) Findings include: 1. The record for Resident #2 was reviewed on 5/9/11 at 10:00 a.m. The resident's diagnoses included but were not limited to, diabetes mellitus. Review of physician orders, dated 12/29/10 and then again on 4/18/11, indicated Novolog Insulin sliding scale twice daily before meals as follows: 151-200=3 units, 201-250=6 units, 251-300=9	R0241	Deficiency #: R241Residents Affected: # 2, #3, #4, #5, #6, and #171. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 2's blood sugar monitoring order has been clarified with the physician.Resident#4's physician was notified and Procrit medication was discontinued. Resident#4's blood sugar monitoring orders have been verified with the physician .Physician has been notified and orders have been obtained for blood pressure monitoring. Resident's blood pressure has been obtained and recorded.Resident#3's specimen has been collected with results relayed to physician has been notified. Resident#6 regular insulin has been discontinued and	06/23/2011

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	units, 301-350=12 units, and 351-400=15 units. If the blood sugar was greater than 400 call the physician and give 18 units. Review of physician orders, dated 12/29/10 and then again on 4/18/11, indicated accucheck (finger stick blood sugar testing) before meals and at bedtime. Review of Glucometer and Insulin Reading Form for the months of 1/11, 2/11, 3/11, and 4/11 indicated staff were only documenting an accucheck reading at 5:00 a.m., and 5:00 p.m., with the sliding scale coverage. There was no documentation of an accucheck completed before the noon meal or at bed time. Review of the Medication Administration Record (MAR) for the months of 1/11, 2/11, 3/11, and 4/11 indicated the accucheck before the noon meal and at bed time were not recorded as being done. Interview with the LPN #1 on 5/10/11 at 2:45 p.m., indicated she was uanware if the the noon accucheck and bed time accucheck were being completed. The LPN indicated she had not taken the resident's accucheck before the noon meal.		insulin administration orders have been clarified. Physician has been notified of the administration of wrong doses of Humulin 70/30 on 5/3 and 5/5/2011. Urine CNS was collected and tested 05/12/2011 and results relayed to physician. Diet order recorded on POS. Resident#5 CMP Lipid Panel HGBA1C was tested and results relayed to physician. Blood Glucose Meter orders were initially obtained 01/31/2011 and were not recorded on POS. Blood Glucose orders now recorded on POS for May 2011 and forwarded to pharmacy.Resident#17 no longer resides in the facility.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents in the facility have a potential to be affected by alleged deficient practice. Resident records are being audited for, medication administration, Procrit administration, blood glucose testing, obtaining ordered lab specimens, and monitoring blood pressure .3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?A new form to record blood glucose monitoring will be instituted. Nurses are being in -serviced on blood glucose testing, Procrit administration, medication administration, obtaining ordered	

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	2. The record for Resident #4 was reviewed on 5/9/11 at 12:10 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, glaucoma, high blood pressure, and lymphoma. The 4/11 Physician Order Statement indicated there was an order for Novolog insulin to be given four times a day per sliding scale per results of glucometer readings (blood sugar levels) at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The insulin was to be given as follows: No coverage for blood glucose levels 150 or less (4) units of Novolog insulin for blood		lab specimens and monitoring blood pressure prior to administering anti hypertensive' s.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The Director of Nursing or designee will perform random audits of resident records on a weekly basis to ensure the compliance with blood glucose testing, Procrit administration, medication administration, obtaining ordered lab specimens and monitoring blood pressure prior to administering anti-hypertensive's. Monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	glucose levels 151-170 (5) units of Novolog insulin for blood glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m. - Blood sugar 262/10 units Novolog insulin given 4:30 p.m.- Blood sugar 263/10 units Novolog insulin given 9:30 p.m. - Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m.- Blood sugar 169/5 units Novolog insulin given 8:45 p.m.- Blood sugar 333/12 units Novolog insulin given			

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	There was no 11:00 a.m. or 4:00 p.m. blood sugar or insulin coverage noted. 4/15/11 5:50 a.m.- Blood sugar 83/ no Novolog insulin given 11:30 a.m.- Blood sugar 281/10 units of Novolog insulin given 4:45 p.m.- Blood sugar 375/15 units of Novolog insulin given There was no 8:00 p.m. blood sugar or insulin coverage noted. 4/17/11 5:40 a.m.- Blood sugar 204/8 units of Novolog insulin given 11:00 a.m.- Blood sugar 322/12 units of Novolog insulin given 8:00 p.m.- Blood sugar 368/15 units of Novolog insulin given There was no 4:00 p.m. blood sugar or insulin coverage noted. 4/19/11 5:45 a.m.- Blood sugar 119/no Novolog insulin given no time indicated- Blood sugar 315/12 units of Novolog insulin given There were no other blood sugars of insulin coverage noted. 4/20/11 5:40 a.m. - Blood sugar 225/8 units of Novolog insulin given			

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		A. BUILDING 00 B. WING	05/11/2011

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	11:00 a.m.- Blood sugar 355/15 units of Novolog insulin given 3:00 p.m.- Blood sugar 325/12 units of Novolog insulin given. There was no 8:00 p.m. blood sugar or insulin coverage noted. 4/22/11 6:00 a.m. - Blood sugar 196/5 units of Novolog insulin given 5:00 p.m. - Blood sugar 186/5 units of Novolog insulin given 9:00 p.m.- Blood sugar 281/10 units of Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted 4/23/11 5:30 a.m.- Blood sugar 122/no Novolog insulin given 5:00 p.m.- Blood sugar 309/12 units of Novolog insulin given 9:00 p.m.- Blood sugar 165/ no Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage given. Inttierview wittih Administtirattio5/10 att1:45 p.m.,indicattied glucomettiers and insulin administtirattion should have been done as ordered by ttiheMD Review of the 5/11 Physician Order Statement indicated there was an order for			

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	the resident to receive Procrit (a medication to treat low blood counts) 10,000 units injection weekly on Fridays. The Physician Order Statement indicated the medication was originally ordered on 11/26/10. The 1/11, 2/11, 3/11, and 4/11 Medication Administration Records were reviewed. On the 1/11 Medication Administration record the Procrit injection was circled as not given on 1/7/11 and 1/28/11. The 1/14/11 and 1/21/11 entries were blank. There was no documentation on the back of the 1/11 Medication Administration Record indicating the reason the medication was not given or not signed out as given. The 2/11 Medication Administration Record indicated the Procrit injection was not signed out as given on any days throughout the entire month. There was no documentation on the back of the 2/11 Medication Administration Record indicating the reason the medication was not signed out as given. The 3/11 Medication Administration Record indicated the Procrit injection was circled as not given on 3/11/11, 3/18/11, and 3/25/11. There was no documentation on the back of the 3/11 Medication Administration Record			

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	indicating the reason the medication was not given. The 4/11 Medication Administration Record indicated the Procrit injection was circled as not given on 4/1/11 and 4/15/11. The 4/8/11, 4/22/11, and 4/29/11 doses were blank. There was no documentation on the back of the 4/11 Medication Administration Record indicating the reason the medication was not given or not signed out as given. Inttierview wittih Pharmacistti on 5/10/11 atti 10:50 a.m., indicattied one dose of Procritti was lastti sentti on 11/26/10. The Pharmacistti indicattied prior ttio ttihatti 11/8 ttiwo doses were sentttion 10/29 one dose was sentttion 10/20 one dose was sentttion 10/14 one dose was sentttiand on 9/16 one dose was sentti Seven doses were sentti since 9/16/10 and ttihe residentti should have been getting itti every Friday. On 5/10/11 atti 1:45 p.m., ttihere were four doses of Procritti observed in ttihe medicattion refrigerattior Interview with LPN #1 on 5/10/11 at 1:45 p.m., indicated the resident should have been receiving the Procrit every week as ordered by the physician. There was also an order for the resident to receive Nifediac CC (a medication for high blood pressure) 30 milligrams one tablet by mouth at bedtime. The order also indicated the Nifediac			

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	CC was to be held if the resident's systolic (top number) blood pressure reading was less then 120. The 1/11, 2/11, 3/11, and 4/11 Medication Administration Records were reviewed. The Nifediac CC medication was signed out as given at 9:00 p.m. 2/1/11 through 2/22/11. There was no documentation of the resident's blood pressure reading prior to the medication being given. The Nifediac CC medication was signed out as given 3/1/11 through 3/31/11 at 9:00 p.m. There was no documentation of the resident's blood pressure reading prior to administering the medication. The Nifediac CC was signed out as given 4/2/11 through 4/27/11 at 9:00 p.m. There was no documentation of the resident's blood pressure reading prior to administering the medication. 3. The record for Resident #3 was reviewed on 5/9/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, chronic renal failure, and asthma. There were Physician's orders written on 10/25/10 and 12/27/10 for stool specimens to be collected for C-Diff (an infection) and sent to the laboratory. Review of the laboratory test results section of the resident's clinical record indicated there was no documentation of results of any stool specimens for C-Diff from 10/10 through current. When interviewed on 5/10/11 at 1:45 p.m., the facility Administrator indicated there were no laboratory results from the stool specimens as the specimens were not obtained. 4. The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that			

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	included, but were not limited to, diabetes, mental retardation and schizophrenia with auditory hallucinations. There was a physician's order dated 3/1/11 for Humulin 70/30 Insulin to be given twice daily. On 4/25/11, the resident was seen by the physician. The physician indicated the resident had insulin dependent diabetes. The physician's impression indicated, "uncontrolled insulin dependent diabetes." The physician ordered check blood sugar before each meal and adjust insulin. On 4/27/11, there was a physician's order for Regular insulin per sliding scale as follows: 150-200 5 units 201-250 10 units 251-300 15 units above 300 call doctor The forms titled "Glucometer and Insulin Reading Form" were reviewed. The forms indicated the date and times of the glucometers and the amount of Insulin administered: 4/26/11 6:20 a.m. Glucometer 261 10 units Humulin 70/30 4/26/11 (no time indicated) Glucometer 247 10 units Humulin 70/30 4/29/11 7:00 a.m. Glucometer 335 10			

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	units Humulin 70/30 5/1/11 8:00 a.m. Glucometer 199 10 units Humulin 70/30 5/2/11 6:20 a.m. Glucometer 250 10 units (no insulin type indicated) 5/3/11 4:30 a.m. Glucometer 255 15 units Humulin 70/30 5/3/11 (no time indicated) Glucometer 291 15 units (no insulin type indicated) 5/4/11 7:45 a.m. Glucometer 246 10 units Humulin 70/30 5/4/11 5:00 p.m. Glucometer 176 10 units Humulin 70/30 5/5/11 6:45 a.m. Glucometer 221 10 units Humulin 70/30 & Novolog regular insulin 10 units 5/5/11 5:30 p.m. Glucometer 284 15 units Humulin 70/30 5/6/11 6:30 a.m. Glucometer 162 10 units Humulin 70/30 & Novolog regular insulin 5 units 5/6/11 5:00 p.m. Glucometer 185 10 units Humulin 70/30 5/8/11 7:00 a.m. Glucometer 275 15 units Novolog regular insulin 5/9/11 6:35 a.m. Glucometer 294 10 units Novolog 15 units There was no documentation for insulin administration or glucometer readings for 4/27, 4/28, 4/30, and 5/7/11. There was incomplete documentation for twice daily routine Humulin 70/30 administration on 5/1, 5/2, and 5/8/2011. There was			

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	incomplete documentation of the before meal Regular insulin sliding scale administration on all days, 4/26/11 through 5/9/11. The glucometer readings before meals were not obtained as ordered by the physician. There was no documentation that the routine doses of Humulin 70/30 insulin and the sliding scale doses of Regular insulin were administered as ordered. On 5/3/11 at 4:30 a.m. and on 5/5/11 at 5:30 p.m., 15 units of Humulin 70/30 were administered to the resident. There was no order for 15 units of Humulin 70/30 to be administered to the resident. Interview with QMA #1 on 5/10/11 at 11:30 a.m., indicated she was unaware of the physician's orders for glucometers with sliding scale before meals. The May 2011 Medication Administration Record indicated the resident was to receive twice daily glucometers. She indicated the May 2011 Medication Administration Record had not been updated with the current physician's order. She also indicated that the glucometer readings had not been obtained as ordered by the physician. Interview with RN #1 on 5/10/11 at 11:35 a.m., indicated she was not aware of the			

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	sliding scale order for Regular insulin. She indicated that wrong doses of Humulin 70/30 were administered to the resident on 5/3/11 and 5/5/11. She indicated that it appeared the staff used the Regular insulin sliding scale dose for the Humulin 70/30 instead of the dose ordered by the physician. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated the staff did not administer the resident's insulin as ordered by the physician. Review of the May 2011 physician order indicated there was no documentation of the resident's current diet. There was a physician's order dated 4/24/11 for a urine culture and sensitivity. There was no documentation of the urine culture in the resident's record. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated the record was incomplete. She indicated the diet was not on the current physician's order and the urine culture was not in the record. 5. The record for Resident #5 was reviewed on 5/9/11 at 12:30 p.m. The resident had diagnoses that included, but were not limited to, congestive heart			

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	failure and diabetes. There was a physician order for routine laboratory tests that included, CMP (complete metabolic profile), lipid panel, and HGBA1C (glycosylated hemoglobin) to be obtained every 3 months. Review of the laboratory tests indicated the last time the lab tests were obtained was 1/12/11. There were no lab results for April 2011. Review of the form titled, "Glucometer and Insulin Reading Form" indicated the resident was receiving glucometer readings daily in April and May 2011. Review of the April and May 2011 Physician Order Sheets indicated there was no physician order for glucometer readings. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated the record was incomplete. She indicated there was no physician's order for the the glucometers and the CMP, lipid panel, and HGBA1C had not been obtained in April 2011. 6. The record for Resident #17 was reviewed on 5/10/11 at 1:45 p.m. The resident had diagnoses that included, but were not limited to, mild mental retardation and psychosis.			

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	There was a physician's order, dated 9/20/10, for stool for ova and parasite and c-dif. There was no documentation in the resident's record of the laboratory test results for the stool for ova and parasite and c-dif. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated the record was incomplete. She indicated the laboratory tests for the resident's stool were not in the record.			
R0300	(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to ensure 8 multi dose vials of insulin were labeled with the date they were first opened for 4 residents in the supplemental sample of 13 and 3 residents in the sample of 11. (Residents #2, #3, #4, #6, #7, #8, and #11). The facility also failed to ensure 4 opened multidose vials of insulin were discarded 28 days after they were first opened 8	R0300	Deficiency R300Residents Affected: #2, #3,#4,#6,#7,#8,#10 and #111. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident's #2, #3, #4, #6,#7, #8, #10 and#11 has been discarded and replaced with labeled insulin vials.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?	06/23/2011

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	days as per the pharmacy policy for 3 residents in the supplemental sample of 13. (Residents #7, #8, and #10). Findings include: The pharmacy "Appendix 23: Recommended Minimum Medication Storage Parameters(based on manufacturer package inserts)" was reviewed on 5/10/11 at 1:00 p.m. There was no date on the Appendix. The Appendix indicated all vials of insulin products were to discarded 28 days after opening. The pharmacy policy titled "Preparation for Medication Administration" was reviewed on 5/10/11 at 1:00 p.m. The policy was dated 10/24/2007. The policy indicated vials and ampules of injectable medications were to be labeled with the date opened and the employees initials when they are opened for the first time. On 5/10/11 at 10:50 a.m., medications in the refrigerator in the Main Nursing Station were observed. There were 3 open vials of insulin in the refrigerator that had been opened longer then 28 days as follows: One vial of Lantus insulin for Resident #7 opened on 3/21/11. One vial of Lantus insulin for Resident		All residents having insulin orders have a potential to be affected by alleged deficient practice. All opened insulin vials have been checked for dates of opening.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?Nurses are being in -serviced on dating and discarding of insulin vials. Policy regarding discarding insulin vials and labeling when opening will be reviewed with nursing staff.4. How the corrective actions will be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will maintain a received and disposal calendar for all insulin vials. The Director of Nursing and/or designee will randomly check vials of insulin in the refrigerator on a weekly basis. Monitoring will be ongoing.5 .By what date the systemic changes will be completed? June 23, 2011	

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	#10 opened on 4/3/11. One vial of Lantus insulin for Resident #8 opened on 4/2/11. One vial of Novolin R insulin for Resident #7 opened 3/20/11 Labels on the above insulin vials indicated they were to be discarded 28 days after they were first opened. There were 8 opened vials of insulin stored in the refrigerator that had labels that indicated they were to be discarded 28 days after they were first opened. The insulin vials were not dated with the date they were first opened as follows: One vial of Lantus insulin for Resident #4 Two vials of Lantus insulin for Resident #11 One vial of Novolin 70/30 for Resident #3 One vial of Novolog insulin for Resident #2 One vial of Humulin 70/30 insulin for Resident #6 One vial of Novolin R insulin for Resident #7 One vial of Novolin R insulin for Resident #8 When interviewed on 5/10/11 at 11:00 a.m., RN #2 indicated the above residents were currently receiving the insulins listed. The RN indicated the insulin vials were to be discarded 30 days from the date they were first opened.			

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	When interviewed on 5/10/11 at 1:45 p.m., the facility Administrator indicated the insulin vials should have been labeled and discarded as per the pharmacy instructions.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interviews, the facility failed to ensure the resident records were accessible, accurate and complete related to, follow up assessment after a fall, diet orders, and medications administered as ordered by the physician, for 4 of 11 sampled residents. (Residents #1, #2, #4, and #16) Findings include: 1. On 5/9/11 at 12:30 p.m. and at 2:00 p.m., the closed record for Resident #1 was requested. Interview with Administrator at 2:30 p.m., on 5/9/11 indicated they was not able to locate the resident's record.	R0349	Deficiency #: R349Residents Affected: #1, #2, #4 and #161. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides in facility but facility will continue all efforts to locate closed record for dates requested by surveyors. Resdent#2 was assessed at the hospital. Resident #4 is currently receiving the Miralax and nurses are documenting on the administration. Resident #16 no longer resides in the facility.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	06/23/2011

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	On 5/10/11 at 9:00 a.m., 10:45 a.m., 12:20 p.m., and 2:45 p.m., the closed record for Resident #1 was requested. Interview with the Administrator on 5/10/11 at 3:00 p.m., indicated they still were not able to locate the resident's closed record. Interview with the Administrator on 5/11/11 at 8:30 a.m., indicated they were not able to locate the closed record and had even called the old Director of Nursing. 2. The record for Resident #2 was reviewed on 5/9/11 at 10:00 a.m. Review of Nurse's Notes dated 4/14/11 indicated the resident had fallen off of the toilet and onto the floor in her bathroom. The resident indicated she had hit her head and there was a bump on her forehead. The resident was sent to the hospital. Nurse's Notes, dated 4/14/11 at 2:00 p.m., indicated the resident had returned from the hospital. There was no vital signs taken at that time or an assessment of the resident's condition at that time. Nurse's Notes, dated 4/14/11 at 4:20 p.m., indicated the resident had a low grade fever of 100.6 degrees and her blood pressure was 140/90. The resident also had complaints of her head hurting. Tylenol 500 milligrams one tablet was		corrective actions will be taken? All residents in the facility have a potential to be affected by alleged deficient practice. All closed records will be placed in a designated area for better accessibility upon request.Resident#2 was hospitalized during survey and was reassessed upon return to facility. Resident #4 is currently receiving Miralax as reflected in Medication Administration Record .Resident #16 no longer resides in the facility, but diet order was found in discharged Kardex of Dietary Orders by Dietary Supervisor.3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?Nurses will be in -serviced on forwarding closed resident clinical records to Director of Nursing or designee, recording medication administration or refusal, recording diet orders, and completing fall assessment. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will ensure all closed resident clinical records are complete and accessible by maintaining a log of location of closed records. Director of Nursing or Designee will randomly check Medication Administration Record on a weekly basis for proper	

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	given for increased temperature and complaints of pain. The next documented entry in Nurse's Notes was on 4/14/11 at 6:15 p.m., which indicated the resident's temperature was 100.2. There was an assessment of the resident's head at that time. Nurse's Notes dated 4/14/11 at 7:15 p.m., indicated the resident was repeatedly slipping out of her chair. She was then taken back to her room and assisted back to bed by two staff members. The CNA had indicated she had to feed the resident her evening meal. The resident had upper body weakness and there was a bruise to her forehead. The resident's temperature was 100.3 degrees. The resident's physician was notified and orders to send the resident to the hospital were received. The resident left for the hospital per ambulance at 8:55 p.m. The resident was admitted to the hospital with a head concussion. Interview with LPN #1 on 5/10/11 at 2:00 p.m., indicated there was no documentation of an assessment done when the resident returned from the hospital on 4/14/11 at 2:00 p.m., nor was any neurological assessment of the resident after she had complaints of her head hurting. 3. The record for Resident #4 was		documentation regarding administration of medication or refusal of such. Director of Nursing or designee will follow up on all fall incidents and maintain ongoing log. The Director of Nursing or designee will check all physician order sheets for current diet orders on a monthly basis. Monitoring will be ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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	reviewed on 5/9/11 at 12:10 p.m. The resident's diagnoses included, but were not limited to, high blood pressure and diabetes mellitus. A Physician's order was written on 3/26/11 for the resident to receive Miralax (a laxative) 17 grams mixed in water daily. Review of the 4/11 Medication Administration Record indicated the medication was only signed out as given on 4/4/11, 4/11/11, and 4/16/11. Entries for the remaining days were blank. Review of back page of the Medication Administration Record indicated there was no documentation related to the Miralax. When interviewed on 5/10/11 at 1:45 p.m., the facility Administrator indicated the documentation on the Medication Administration Records was not completed as required. 4. The closed record for Resident #16 was reviewed on 5/9/11 at 2:30 p.m. The resident had diagnoses that included, but were not limited to, insulin dependent diabetes and hypertension. Review of the January 2011 physician order indicated there was no documentation of the resident's diet.			

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	Interview with the Administrator on 5/10/11 at 2:45 p.m. indicated the Physician's Order Sheet was incomplete and did not include the resident's diet.			
R0378	(b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual.			
	Based on record review and interview, the facility failed to ensure a mental health needs evaluation was completed for 1 of 1 residents with mental illness, in the sample of 11. Resident #6 Finding includes:	R0378	Deficiency #378Residents Affected: #61. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 had a mental health screening done by St. Catherine's Hospital	06/23/2011

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	The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health needs evaluation completed for the resident.		Behavioral Health on October 26, 2010. Resident#6 also had a mental health screening done February 1, 2011 by Regional Mental Health. A copy has been placed on Reident#6's clinical record.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Residents who have major mental health diagnoses have the potential to be affected by the alleged deficient practice. All residents that have major mental health diagnoses clinical records are being audited.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The admission team of the facility will be in serviced on ensuring that any resident with a major mental health diagnosis will have a mental health screen completed prior to admission. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? The Director of Nursing or designee will complete a preadmission evaluation form which include mental health screening section on all new admits prior to admission to facility. The Administrator or designee will monitor for compliance ongoing.5. By what date the systemic changes will be completed? June 23, 2011	

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R0407	(b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review and interviews, the facility failed to ensure the proper use of gloves and disinfecting solution was used during glucometer cleaning for 1 resident in the sample of 11, (Resident #5) and for 1 resident in the supplemental sample of 13, (Resident #11)	R0407	Deficiency #: R407Residents Affected: #5, and #111. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 and #11 Glucometer's were cleaned with a Bleach Wipe by nursing staff wearing gloves.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents on Glucometer testing in the facility have a potential to be affected by alleged deficient practice. All Glucometers have been disinfected with bleach wipes by nursing staff wearing gloves.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nurses will be in serviced on the proper cleaning method of Glucometer using Bleach Wipes as recommended	06/23/2011

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	Findings include: QMA #1 was observed on 5/10/11 at 11:00 a.m. recording glucometer readings for the residents. She gave Resident #5 an Assure Platinum glucometer. The resident obtained the blood sample and the glucometer reading herself. She then returned the glucometer to the QMA. The QMA cleaned the glucometer with an isopropyl alcohol 70% pad. The QMA was not wearing gloves.		by manufacturer. In addition nurses will be in-serviced on cleaning Glucometers wearing gloves.4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Nursing staff will be monitored monthly at random by Director of Nursing or designee during blood glucose testing for cleaning of Glucometer and performance documented. Monitoring will be ongoing.5 By what date the systemic changes will be completed? June 23, 2011	

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	Resident #11 then came to the nurse's station. The QMA gave the resident a Liberty glucometer. The resident obtained the blood sample and the glucometer reading and returned the glucometer to the QMA. The QMA cleaned the glucometer with an isopropyl alcohol 70% pad. She was not wearing gloves. Interview with the QMA on 5/10/11 at 11:15 a.m., indicated each resident has their own			

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	glucometer. All the glucometers were placed in separate boxes in a cart. The Assure Platinum User Instruction Manual was reviewed on 5/10/11 at 12:15 p.m. The manual indicated that for cleaning, "Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the			

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	meter between patients. Clean the outside of the meter with a lint-free cloth. Dampen with soapy water or isopropyl alcohol (70 - 85%). To disinfect the meter, dilute 1 ml (milliliter) of household bleach (5% -6%) sodium hypochlorite solution) in 9 ml of water. This is a 1:10 dilution. The final concentration is 0.5 -0.6% sodium hypochlorite. Do not clean inside the battery compartment or test strip port."			

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	The "Owner's Booklet" for the Liberty glucometer was reviewed on 5/10/11 at 12 30 p.m. The cleaning instructions indicated the glucometer should be cleaned with a cloth dampened with a soapy solution. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated staff should have worn gloves for the cleaning of the glucometers. The Administrator was informed of the User Instruction Manual for			

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	the use of bleach disinfection solution.			
R0409	(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a tuberculin skin test was completed annually for 1 of 11 sampled residents who were reviewed for tuberculin testing. (Resident #3) Findings include: The record for Resident #3 was reviewed on 5/9/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, asthma, and chronic renal failure. The resident was admitted to the facility on 4/4/07. The resident's current immunization record was reviewed. The last Mantoux tuberculin skin test was administered on 3/25/10. The tuberculin skin test was read on 3/28/10. When interviewed on 5/10/11 at 1:45	R0409	Deficiency #409Residents Affected: #31. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #3 given annual TB test.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents in the facility have a potential to be affected by alleged deficient practice. Residents are currently being administered TB tests.3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nurses will be in serviced on administering all TB testing at as when due. Director of Nursing or designee will compile a list of residents with their annual due dates for TB testing and will distribute list to nurses to administer.4 How the corrective actions will be monitored to ensure the deficient	06/23/2011

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	p.m., the facility Administrator indicated the resident should have had a tuberculin skin test annually.		practice will not recur? Director of Nursing or designee will check monthly listing and will audit for compliance. Monitoring will be ongoing.5 . By what date the systemic changes will be completed? June 23, 2011	